BlueChoice®†

Anthem

POS - Summary of Benefits

*This is only a brief summary of your coverage. Benefits apply when care is **medically necessary**. Services are covered up to the Maximum Allowable Benefit (MAB). Network providers agree to accept the MAB as payment in full. However, if you receive self referred services from an out-of-network provider, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost		
You will pay less if these services are provided or referred by your Primary Care Provider (PCP).			
Preventive Care	***Option 1*** **PCP Referred Benefits**	***Option 2*** **Self Referred Network Benefits**	***Option 3*** **Self Referred Out-of-Network Benefits***
• Immunization, lead screening, PSA (prostate screening)	Covered in full	Covered in full	Covered up to MAB
• Routine physical exam including family planning visits and well baby care	$ 10 per visit	$ 30 per visit	Subject to:
• Routine hearing exam *(one exam per year under age 19)*	$ 10 per visit	$ 30 per visit	$ 150 deductible per member, no more than $ 450 per family per calendar year▲ and
See "Other Services" for additional Preventive Care information			
Other Outpatient Care			
• Medical exam	$ 10 per visit	$ 30 per visit	
• Injections and office surgery	Covered in full		
• Lab, X-ray and ultrasound	Covered in full	Subject to:	20% coinsurance up to $900 per member, no more than $2,700 per family per calendar year▲
• Physical and occupational therapy *(combined up to 25 visits per member per medical episode)*✪	Covered in full		
• Speech therapy *(up to 25 visits per member per medical episode)*✪	Covered in full	20% coinsurance up to $600 per member, no more than $ 1,800 per member per calendar year▲	Some self referred benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify.
• CT scan and MRI	Covered in full		
• Surgery in hospital outpatient department or ambulatory surgery center	Covered in full		
Inpatient Care (as a bed patient in an acute care hospital)			
• Semi-private room and board	Covered in full		
• Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy	Covered in full		
Skilled Nursing Facility and Rehabilitation Facility Care *(combined up to 30 days per member per calendar year)*✪	Covered in full		
Durable Medical Equipment (DME)	Covered in full	20% coinsurance▲	$100 DME deductible 20% coinsurance▲

✪ Any combination of benefits from any column counts toward this maximum.

✻ Services are covered up to the MAB. Out-of-network providers may bill you for amounts that exceed the MAB.

▲ Deductible and/or coinsurance amounts are shared among all columns.

These services DO NOT require a PCP referral. Your benefit is determined by whether you choose a network provider or an out-of-network provider.

Other Services	***Option 1*** **Network Benefits**	***Option 3*** **Out-of-Network Benefits***
• Routine vision exam *(one exam per year under age 19, one exam every 24 months for age 19 and over)*	$ 10 per visit	Subject to deductible and coinsurance▲
• OB/GYN care (performed by an OB/GYN provider)		
- Exam	$ 10 per visit	
- Maternity care (routine prenatal, delivery and postpartum)	Covered in full	
- Mammogram and Pap smear	Covered in full	Covered up to MAB
• Chiropractic visit.*(20 visits per member per calendar year)*	$ 10 per visit	Subject to deductible and coinsurance▲
- Chiropractic X-ray	Covered in full	

These services DO NOT require a PCP referral for medical emergencies as defined by your Subscriber Certificate.

Emergency Room (ER) Visit	***Option 1*** **Network Benefits**	***Option 3*** **Out-of-Network Benefits***
• ER charge *(copayment waived if admitted)*. . . .	$ 10 per visit	Same as Network Benefits
• ER physician fee, CT scan, MRI, medical supplies, etc.	Covered in full	
Ambulance (medically necessary emergency transport only)	Covered in full	

For these services no PCP referral is required, but <u>ALL</u> care must be authorized in advance by Behavioral Health Network (BHN) at 1-800-228-5975. You will pay less if you utilize a network provider.

Mental Health and Substance Abuse (MH/SA)	***Option 1*** **Network Benefits**	***Option 3*** **Out-of-network Benefits***
• Outpatient services - Visit/consultation	$ 10 per visit	Subject to deductible and coinsurance▲ Inpatient and outpatient substance abuse benefits are limited to $ 5,000 per member per year and $10,000 lifetime maximum per member.✪
• Inpatient services - Semi-private room & board	Covered in full	
- MH/SA physician visit	Covered in full	
(Inpatient days for substance abuse are limited to detoxification only.)		

✪ Any combination of benefits from any column counts toward this maximum.
✻ Services are covered up to the MAB. Out-of- network providers may bill you for amounts that exceed the MAB.
▲ Deductible and/or coinsurance amounts are shared among all columns.
✖ These limitations do not apply to biologically based mental illness.

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Prescription Drugs

	Option 1 Network Benefits	*Option 3* Out-of-network Benefits*
Covered medications, diabetic supplies and contraceptive devices purchased at any pharmacy • Includes maintenance drugs at a retail or mail order pharmacy - Only certain drugs are considered "maintenance" and are available for a supply greater than 31 days. • Important notes: - You pay the generic copay for diabetic supplies. - Refer to your prescription drug program flyer for details.	$ 2 copay /generic $ 6 copay / brand $2 copay for mail order for a 90 day supply. Copayment applies to each fill, up to a 31-day supply at a retail pharmacy.	Same as Network

Exclusions and Limitations

The services listed below are not covered by this plan. Please review your Subscriber Certificate for complete details on exclusions and limitations.

Services Not Covered

•Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Artificial insemination and assisted reproductive technologies • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Subscriber Certificate as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, breast pump, routine hearing exam and hearing aids (except for children under 19), eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Sterilization reversal • Weight reduction management and control except diabetes education and nutritional counseling

Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct

This is only a brief summary of your coverage.

This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Subscriber Certificate, which will be mailed to you after you enroll.
If you need further information, call Customer Service at **1-800-942-3733**.

† BlueChoice is administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan

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